UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF OHIO

WESTERN DIVISION

ESTATE OF ROGER D. OWENSBY JR., et al.,	:	
Plaintiffs,	:	
vs.	:	Case No. 01-CV-769
	:	(Judge S. A. Spiegel)
CITY OF CINCINNATI, et al.,	:	
Defendants.	:	

VOLUME I

Deposition of DANIEL L. SCHULTZ, M.D., a witness herein, called by the plaintiffs for cross-examination, pursuant to the Federal Rules of Civil Procedure, taken before me, Wendy Davies Welsh, a Registered Diplomate Reporter and Notary Public in and for the State of Ohio, at the Frank P. Cleveland, M.D. Institute of Forensic Medicine, Toxicology and Criminalistics, 3159 Eden Avenue, Cincinnati, Ohio, on Wednesday, December 17, 2003, at 11:57 a.m.

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STIPULATIONS

It is stipulated by and among counsel for the respective parties that the deposition of DANIEL L. SCHULTZ, M.D., a witness herein, called by the plaintiffs for cross-examination, pursuant to the Federal Rules of Civil Procedure, may be taken at this time by the notary; that said deposition may be reduced to writing in stenotype by the notary, whose notes may then be transcribed out of the presence of the witness; and that proof of the official character and qualifications of the notary is expressly waived.

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A. I made an inverted T-shaped incision extending from the back of the head down below the shoulder blades to look for any hemorrhage or injury. And when I did that, in the, basically, the rhomboid muscles which are between the scapul-- overlie the scapulae, there were hemorrhages.

Now, there weren't any bruises or abrasions noted on the skin of the back, and there wasn't any significant appreciable hemorrhage in the fatty tissues of the back, but it was localized fairly symmetrically within those deep muscular tissues over the scapulae.

So my interpretation of that is a deep injury to the muscles, causing tearing of blood vessels in those muscle groups resulting in the hemorrhage. Because I don't have any pattern injuries, marks, abrasions, contusions on the skin overlying these deep muscular injuries, my interpretation is that they're more likely due to a localized pressure and like a grinding or localized pressure placed on those muscle groups rather than an impact, a direct impact.

Q. If it was a direct impact, say by a nightstick or a punch, would you expect to find

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contusions in the skin or the subcutaneous level of the skin above those deep muscle bruises?

A. I would expect to see any one of these combinations: Either some abrasion to the skin, some bruising to the outside of the skin, some bruising, hemorrhage in the subcutaneous fat.

Because in light of the magnitude of the hemorrhage in those muscle groups, it's not a trivial injury there, and it's remarkable to me that I don't see anything overlying it. So that is why I favor that those injuries to the muscle groups are not due to a blow or blows.

Q. Did you document this finding in the photographs that you took?

A. Yes.

Q. Would you point those out for us? You can just refer to the last three digits.

A. Yeah. 265 through 270 all document various portions of the neck dissection and back dissection. The hemorrhages in the muscle groups are shown in 265, 266, 267, 268, and 269. 270 shows an extension of that incision to look for further hemorrhage in the lower aspect of the back, which I did not appreciate.

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Q. If we look at 267, am I correct in understanding that the blackened or darkened portions in the area of the shoulder blades on either side are the contusions?

A. Yes.

Q. You measured these and they were between three and four inches in diameter?

A. Yes.

Q. Your findings, and in this respect do you make those findings within a reasonable degree of medical certainty in the field of pathology?

A. Yes.

Q. Let's move on. You then, in your report on page 3, you talk about the lungs being "extremely congested and edematous." Do you see that? It's after the first paragraph. It's one line on page 3.

A. Are we in the respiratory system?

Q. No. Up above where it says --

A. Body cavities?

Q. You have a heading of Upper and Lower Extremities, and then right above that.

A. Oh. Yes.

Q. Would you explain that for us?

A. The reason it's listed in that area,

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although heavy lungs, congested lungs, are technically a nonspecific finding, meaning you can see it with other things, he doesn't have any other things to explain it. Meaning, he doesn't have -- he didn't die from heart disease, he didn't die from pneumonia, he didn't die from drug intoxication, which all can cause heavy edematous lungs.

But the only thing he has in the constellation of the findings are petechiae, evidence of compression of his back, evidence of an asphyxial death. The lungs in asphyxia typically become congested and edematous. And so that is why that is listed in that area, because it's technically -- it's an associated finding. That's why it's listed there.

Q. Where are the lungs in relation to the deep muscle hemorrhages that you found?

A. Well, they're in the chest cavities. They're not directly -- it's not because they're contiguous with that area.

It's just when a person dies from an asphyxial death, meaning they're not getting adequate oxygen supplied to their brain and their organs, the heart works faster, blood is pumped to

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the lungs, there's an attempt by the body to have, in response to this, increased oxygen exchange and more flow to the lungs. Subsequently, that flow leads to swelling and edema, which is water on the lung, essentially. They're heavy.

Q. We then have your examination of the body cavity on the internal examination. Is there anything remarkable in that paragraph there about the body cavity concerning these findings?

A. Well, there were a few rare petechiae, and those are nonspecific, on the heart, the surface of the heart. You can see those in a lot of things. So those are specifically listed in that area because I consider them not -- nonspecific.

He was congested. That's, again, nonspecific. But in light of what the big picture is, it's consistent with what he died from, which is an asphyxial event.

Q. You then examined the cardiovascular system. The heart weighed 395 grams. Is that what you would expect for a normal heart of a person this age?

A. Yes.

Q. Why is it that in conducting an autopsy the various organs are weighed?

A. Well, the organs are weighed because we look at reference values or we have certain reference values that we have known to come to accept as reasonable weights for various organs.

Probably the most important organ to weigh is the heart. The other organs -- and the lungs. The other organs probably don't matter so much. But it's just another element of documentation that we use to describe a body.

Q. If the organ is outside of the expected weight, is that some sort of signal to investigate further?

A. Well, if, for example, I -- I had found, for example, that there was an enlarged heart and/or coronary artery disease of significant degree that would explain his death and the circumstances then, depending on how the circumstances pan out, then opinions might change.

So every organ is looked at individually and in light of the total body exam, and then I make an opinion overall as to the terms of the cause of death. But no one organ stands alone, generally. You interpret them in light of everything else.

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Q. In the paragraph on the cardiovascular system examination you talk about the descending coronary artery having a 50 percent obstructive plaque situated in the mid portion. Do you see that?

A. Yes.

Q. In your opinion, to a reasonable degree of medical certainty in the field of forensic pathology, did that play any part in causing the death of Mr. Owensby?

A. No.

Q. Why not?

A. Because the 50 percent obstructive -- first of all, I have never had anyone die from a lesion of 50 percent, okay.

Second of all, most forensic pathologists, certainly that I have worked with, trained with, they like to see lesions above 75, roughly 70, 75 percent obstructed before they would even consider that as a cause of death. And if you were to have that kind of lesion, you would then take that in context of the circumstances. But his doesn't even come close to that level.

I did put a section in microscopically,

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which, you know, when we look at things microscopically you take something you see with your naked eye that, as you look at it, you say it's 50 percent. Subsequently, an histologist takes that, cuts little pieces off to look at it on a slide and it never gets worse than what you see with your naked eye, but sometimes it gets better. Meaning the lesion sometimes looks less obstructive. And that's not surprising.

So typically what I say when I look at cases like that is I always know what my gross impression is, which is my naked eye. I will either say it's consistent with, or if it comes out and there's nothing on there, I'll put another section in or I'll figure out why.

But in his case, his histology was consistent with what I saw, namely, he did have an atherosclerotic plaque, but it certainly wasn't more than 50 percent obstructive.

Q. Is there anything else about the cardiovascular system, any findings one way or the other that are worth, or contribute to your opinion in this case?

A. Grossly and microscopically on examination

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of his heart, cardiovascular system, I did not find anything that would have caused or contributed to his death.

Q. Let's move on to the respiratory system, which we already talked about with the lungs being congested. You said that the lungs weighed 860 grams and 765 grams respectively, the right and left lungs. Is that above what you would normally expect a lung to weigh?

A. Yes.

Q. What is the normal weight or range of weights?

A. There is no one normal weight, but I can tell you that generally, normal lungs that aren't congested weigh roughly around two to 400 grams, roughly.

I don't really pay attention to charts where I say, "Oh, I" -- this is clearly well above. This is just very heavy. From my standpoint and experience it's very evident that they're heavy.

Q. You then talk about a maroon-purple congested appearance. If the lungs were not congested, a normal healthy lung, what would you expect the color to be of the lungs?

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A. If it's a person who is not a smoker I would expect them to look pink-tan in color. If they're a smoker I would expect them to look pink-tan with some black and green soot in the lungs.

I didn't appreciate soot in his lungs, but they were very purple and congested, and it's entirely possible there had been evidence of that as well, but I couldn't see it.

Q. Do you know what causes the maroon-purple color in the lungs?

A. Blood.

Q. So it's blood leaching or --

A. Well, it's not -- certainly there can be -- let me refer to my micro so I speak -- okay.

The purple color, maroon coloration, is due to a combination of things. It's due to the vessels that supply what are called the septae of the lungs. Because there are air sacs. And those air sacs are surrounded by septae, which is where the vessels come in to supply the blood. Those vessels become intensely congested and they're distended and dilated with red blood cells.

Now, in a person who doesn't have a

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congested pulmonary vascular circuit their lungs look tan-pink because their vessels aren't distended. When they become distended with blood cells the whole lung or whatever area's involved will have a maroon-purple color.

In addition, there's some additional coloration changes, because there's some hemorrhage in the alveolar air spaces. And that's due to the increased pressure, and it actually leaks from those capillaries into the air sacs of the lungs.

Q. So in a case such as this with asphyxia, the heart is pumping more blood into the lungs to try and get more oxygen for the body?

A. Yeah, it's trying to get -- the body as a response to the hypoxia, or the lack of oxygen, is to try to pump more blood through the heart and pick up more oxygen and transport it to the rest of the body.

Q. If the lungs can't expand to provide that oxygen then the blood keeps coming into the lungs, and is that where you have the edema and the -- resulting in the maroon-purple color?

MR. FREUND: Object.

A. Yes.

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MR. FREUND: I guess, I never did ask you. Is this supposed to be for purposes of trial? If it is, you're leading the witness.

MR. MARTINS: Okay. I'll rephrase it.

BY MR. MARTINS:

Q. Could you explain to us the process, the physiological process, that's going on that results in the maroon-purple color?

A. Well, as I said earlier, in response to the low oxygen, the hypoxia, the cardiovascular system shunts blood to the lungs. Blood is pumped through the lungs in an attempt to pick up more oxygen. The lungs become congested. They may also leak some red cells and/or fluid, edema fluid, into the lungs, and that is the reason for this occurrence.

Q. Is there anything else in the respiratory system examination that is worth noting in respect to your ultimate findings here?

A. Pertinent negatives are that I did not see any emboli, which are, like thromboemboli, which are blood clots that may come from the legs, which are referred to as pulmonary emboli. I did not see any of that. It's another possible natural cause of

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you describe to us what number 271 is.
A. On 271, this is an image of the tongue. Now, the tongue has been cut in what's called a coronal plane, meaning if I were to run a plane through my body it would be running from -- let's see, parallel to my chest plate, you know. That's a coronal plane. It would run like this, as I'm showing with my hands, I'm sorry.
But through the tongue it would be in the same plane, going -- slicing downward through the tongue. When I do that I look at the tongue and I see hemorrhage in the left side of the tongue, which I document with the photograph.
Q. You have, the next thing on your report is the head and central nervous system. Is there anything remarkable about your examination about the head and the central nervous system, CNS?
A. No.
Q. Move to the later brain examination after fixation. You indicate that there was a Neuropathology Conference held on November 15, 2000. Would you explain what that is?
A. Well, because of the circumstances, and I wanted to exclude any possible other reason for his

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death, the brain was saved for examination with the benefit of a neuropathologist, Dr. Balko, namely.
Also pathologists from this office are at this meeting, and the individuals are listed. That would be the sum total of individuals present during the exam: Dr. Balko, Dr. Pfalzgraf, Dr. Utz, Dr. Tobias, who was our fellow at the time, and myself. It was unremarkable.
Q. In this conference I guess everybody examines some aspect of the tissue or weighs in on, exchanges ideas?
A. What happens is Dr. Balko -- we all look at the brain. I've already looked at it once before it was even put in the fixative, and I at first saw nothing, initially.
Then Dr. Balko takes that brain and then he takes -- slices through the brain in that coronal, C-O-R-O-N-A-L, plane, much like a CAT scan, the same kind of, similar orientation to a CAT scan, to look for any hemorrhages, tumors, injuries, which there were none.
And we watch, and we comment if we see something or we point something out. I don't recall any comments there, because it was essentially a

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negative brain exam.
Q. Then we have the microscopic examination that you set out in your report. Is there anything remarkable about the microscopic examination that contributed to your findings?
A. Well, I noted that there was -- I confirmed there was hemorrhage in the trapezius muscle, which was no new news -- it was no news, I just documented it. There was no inflammatory reaction, which is consistent with this happening within minutes of his death, okay. Seconds to minutes for that matter, but minutes at the most, not hours.
His heart was sectioned for microscopic examination, and they were unremarkable. The coronary artery that we referred to earlier was examined and, as I said, it confirmed my gross impression of a 50 percent obstructed eccentric atherosclerotic plaque. But otherwise, the heart is unremarkable.
The lung sections showed some occasional foci, or collections of aspirated loose mucoid material, and some bacterial flora, which is like we see in the mouth, consistent with some element of

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aspiration, little tiny bits. But no inflammatory reaction was present. Of course that takes minutes, many, many, many minutes to hours to see inflammatory reaction. So this is a terminal type of event.
No -- I had already known from the gross exam that there were no airways that were, quote, "chock-full" of food. It's very thin in the airways. I noted some patchy areas of intraalveolar hemorrhage as well as congestion, as I had already known.
I polarized the lungs as well with a polarizing filter in order to determine if he had any evidence of crystals in the lungs. Now, at the time -- I do this very frequently on cases if I have any inkling that the person may have been doing, or using, drugs, specifically intravenous drugs or cocaine.
I look at the lungs, I rotate these filters. And if I see crystals in the lungs, then I know, I can say, for example, that they're an IV drug abuser or that they had inhaled or insufflated various drugs. He didn't have any evidence of that in his lungs.

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The tongue section was taken and it confirmed my gross impression. There was hemorrhage in the tongue, no inflammatory reaction. It was a bite mark to the tongue, hemorrhagic bite mark to the tongue.

Q. On the last page are some laboratory results. Again, I guess, confirming what you've already said, that there was no cocaine or you have metabolites. What are metabolites?

A. Well, metabolites are what happens to a drug or a chemical after the body has metabolized it. So it's, after metabolism, it's what the drug becomes.

Q. Cannabinoids, that would be the marijuana?

A. Yes.

Q. As I understand it, the finding on the marijuana was 16 thousandths of a milligram per liter?

A. Correct.

Q. Am I reading that correctly?

A. Yes.

Q. As a result of this, did you reach an opinion as to the cause of death of Mr. Owensby?

A. Yes.

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Q. What was your opinion to a reasonable degree of medical certainty in the field of forensic pathology, as to the cause of death of Mr. Owensby?

A. Cause of death, mechanical asphyxia.

Q. Would you explain to us what mechanical asphyxia is?

A. Well, it is a form of asphyxia that is due to physical compression of the chest. And although -- I use it in a rather broad form. Although I recognize that I could be seeing this constellation of symptoms from, or findings from, compression of the chest, I can also see it from compression of the neck.

Now, I use the broad term "mechanical asphyxia." You will find that there is varying definitions of this term. My definition is, it's from a compression of the body in some locale, whether it's chest or neck, resulting in asphyxia.

I don't think either of those scenarios are mutually exclusive. Both or one of those two certainly could have taken place. But in any event, it's still a mechanical pressure applied, resulting in asphyxia.

So, you know, I hope that my term is more descriptive.

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Q. On Exhibit 103, the first page, where your opinion is listed, under mechanical asphyxia you have listed three sub-headings. Did you mean those to, I guess, explain how you arrived at your mechanical asphyxia opinion?

A. I list those there because I think those are part and parcel to the criteria that I might use to bolster my opinion that this is, in fact, a mechanical asphyxia.

Q. That would be the hemorrhages found in the eyes?

A. Right, the conjunctival petechiae with the scleral hemorrhages, terminal emesis or terminal vomiting. Very commonly seen when a person is hypoxic, they may vomit. In fact, that's very common. And the hemorrhagic bite mark, whether that's from a seizure or whether that's from biting his tongue during the process of the restraint, I don't know. But I list it in that area as well, because it's part of the terminal events, I feel.

Q. Does the congestion of the lungs also support the finding of mechanical asphyxia?

A. Sure.

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Q. How so?

A. Because, as I said, with an asphyxial death one expects the lungs would be rather congested. It's -- well, in terms of what I decide to actually list under that heading, I probably could list more or less. It's the art of listing these things on the diagnosis list. It certainly could have been listed there as well.

Q. Let me ask you, did you see anything that was inconsistent with mechanical asphyxia?

A. No.

Q. You also list several other items under diagnosis, which I believe we've already talked about, the abrasions, the deep back muscular contusions, the facial abrasions and knees and forearm. And then the cause of death you list is mechanical asphyxia. You also have a heading of Manner of death. Would you explain to us the difference between a cause of death and a manner of death?

A. Manner of death is how the cause came about.

Q. Here you wrote, "Homicide," and then in parenthetical phrase,"(police intervention:

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A. No.
Q. He had abrasions of his legs and he had abrasions of his arms; is that right?
A. Yes.
Q. No fractures of any bones?
A. Correct.
Q. As a forensic pathologist you give opinions as to what you believe caused the death; that's basically your job, is that fair?
A. Yes.
Q. But it is not your job to, for example, come in and say that Mr. Owensby did or did not resist arrest, true?
A. I can't speak for that event. I can say he has abrasions that are consistent with such. Everything else is historical.
Q. Okay. Nor is it your job to come in and say whether or not the officers did or did not use reasonable force; is that true?
A. True.
Q. From your autopsy were you able to determine the length of time that there was compression to the chest?
A. Minutes.

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MR. WEISENFELDER: I'm sorry?
THE WITNESS: Minutes.
Q. That's based upon your opinion. Do you know how long there was compression to the chest, if there was compression to the chest?
A. Minutes.
MR. MARTINS: Objection. Asked and answered.
Q. When you say "minutes," could you explain to me how you know that.
A. I know that because he has no natural disease, no drug toxin causing his death. His death is a consequence of mechanical asphyxia. That takes minutes. The chest --
Q. So it's kind of reverse engineering?
A. Absolutely. It's by exclusion. Sometimes we work backwards.
Q. Okay. Do --
MR. MARTINS: Wait. I don't think the witness is finished giving his answer.
Q. You can finish.
A. So my point is, he died from mechanical asphyxia.
Q. That's your opinion?

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A. Absolutely. But now -- because everything's been excluded completely.
Q. In your opinion?
A. Absolutely. Absolutely.
Q. Are you ever wrong?
A. Am I ever wrong?
Q. Yes.
A. Yes.
Q. Talk to me about Sudden Cardiac Death.
A. Sudden Cardiac Death is when a person dies due to a sudden cardiac event.
Q. Especially in young people, there can be no known etiology or cause for that event; is that correct?
A. Sometimes. Yes, it can happen that there's no known cause.
Q. Sometimes the cause for a Sudden Cardiac Death can be extreme physical exertion; is that correct?
A. If there's an underlying natural disease present.
Q. Am I also correct that there does not have to be an underlying natural disease process in order for someone to suffer from Sudden Cardiac Death?

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A. That's incorrect.
Q. In your opinion, in your opinion, there always has to be some underlying cause; is that correct?
MR. MARTINS: Objection.
A. Yes. There is a cause. There has to be a cause.
Q. Is there always a cause, a physical cause, for cardiac arrhythmias?
A. Well, since you used the term "physical cause," are you meaning due to a physical blow or are you referring to a chemical or are you referring to -- what are you referring to?
Q. I'm referring to an underlying etiology.
A. There's always a cause.
Q. Can you do an autopsy on someone who suffers a Sudden Cardiac Death without any findings?
A. It's very rare. And then I don't have other circumstances that would suggest otherwise.
Q. Have you ever done an autopsy on someone who's suffered from Sudden Cardiac Death?
A. Yes.
Q. Have you ever done an autopsy on someone who has suffered from Sudden Cardiac Death, without

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any specific findings, other than the fact that the person is dead?
A. Not on an adult.
Q. Not on an adult?
A. Correct.
Q. How about young people and children?
A. We call that SIDS.
Q. I'm not talking about -- how about teenagers engaged in sports?
A. No.
Q. How about --
A. I've done autopsies, but I've never had a death that was Sudden Cardiac Death that I did not explain by some reasonable means.
Q. How many of those have you done?
A. Well, I've done over two thousands cases.
Q. No. How many Sudden Cardiac Deaths have you had where the person was not suffering from heart disease?
A. Hundreds.
Q. If the person is not suffering from heart disease and dies from a cardiac arrhythmia, what have been the causes, in your experience?
A. If they die from an arrhythmia, it could

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be due to cocaine, it could be due to toxins, such as cocaine. It could be due to -- another reason for Sudden Cardiac Death is something like a blood clot, like a pulmonary embolism.
That's not heart disease, per se, but that causes sudden cardiac standstill and death. So there are other, as I said, there are other things that can cause it.
Q. What besides cocaine, and what was the other one you said?
A. Well, cocaine and pulmonary embolism is a possibility.
Q. What other possibilities are there?
A. Well, in an otherwise apparently healthy person, it's pretty much heart causing sudden death or brain.
Q. Have you ever written on the subject?
A. On Sudden Cardiac Death?
Q. Yes.
A. No.
Q. Do you know who Barry Maron is?
A. No.
Q. Did you ever hear of him?
A. No.

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Q. All of the external manifestations of his injuries, the abrasions and the contusions and things like that, that is all consistent with resisting arrest, would you agree with that?
A. Yes.
Q. They surely didn't kill him? In other words, he didn't die from those abrasions and the things that we can see externally, would you agree with that?
A. Well, let's back up. Your entire statement was, "They didn't kill him. . . " these -- okay. Yes, they did. That's why he's dead.
Q. You said in your court testimony that you can't say that he died from those abrasions or impacts, they are just the results of a struggle?
A. Right.
Q. That's what you said in your prior testimony?
A. Correct. That's the same thing. Those are markers of the struggle.
Q. You agree with that?
A. Yes.
Q. You agree that he didn't die from hitting his head on the ground or from the blows that he may

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have received from the officers when they were trying to restrain him?
A. Correct.
Q. You cannot say that Mr. Owensby died because somebody put a chokehold on him; is that correct?
A. Correct.
Q. You were asked a leading question by counsel regarding the definition of homicide. All that "homicide" means is a death caused by an outside source; isn't that true?
A. No.
Q. All right.
A. Would you call it a homicide if you get struck by lightening?
Q. I don't know. What would you call that?
A. I would call that an accident.
Q. Okay. Can a homicide result from somebody resisting arrest?
A. Yes.
Q. Can that be an accident, if somebody dies when he is resisting arrest and, unfortunately, becomes deceased?
MR. MARTINS: Objection.